MDR Tracking Number: M5-04-3216-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 5-24-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The IRO has determined that the therapeutic exercises rendered on 11/3/03, 11/5/03, 11/7/03, 11/10/03, 11/12/03, 11/14/03, and 11/17/03 as well as the office visit on 11/26/03 **were** medically necessary. The chiropractic manipulations, office visits (except on 11/26/03), consultations, mechanical traction, supplies, motor nerve conductions studies with and without F wave, sensory nerve conduction studies, H reflex, needle EMG, and manual therapies rendered from 11/3/03 through 11/24/03 as well as the therapeutic exercises rendered on 11/24/03 **were not** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 14, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 99080-73 for date of service 11/14/03: The carrier denied this code with a V for unnecessary medical treatment based on a peer review, however, per Rule 129.5, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and, therefore, **reimbursement is recommended** in the amount of $15.

CPT code 99455-V4-WP for date of service 12/12/03 was denied by the carrier with a V for unnecessary medical treatment based on a peer review, however, according to Rule 134.202 (6)(B)(iii), this exam is not subject to IRO review. The requestor billed the above service in accordance with Rule 134.202 (e)(6)(D)(II)(-b-) for an MMI/IR rating of 2 musculoskeletal body areas with range of motion. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service, therefore, **reimbursement is recommended** in the amount of $553.24.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with Medicare program reimbursement methodologies per Commission Rule 134.202 (c) and (e)(6)(D) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 11/03/03 through 12/12/03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 21st day of October 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

Enclosure: IRO Decision

7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION – AMENDED DECISION

Date: October 18, 2004

To The Attention Of: Rosalinda Lopez
TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:
MDR Tracking #: M5-04-3216-01
IRO Certificate #: 5242

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Claims bills and explanation of benefits
- Letter of medical necessity from Bryan Weddle, D.C.
- Therapeutic exercises treatment notes
- SOAP notes

- MRI reports
- Physical performance evaluation report

Submitted by Respondent:

- Peer review performed by Brad McKecknie, D.C.

Clinical History

According to the supplied documentation it appears the claimant was injured on ___ when she slipped and fell on steps at the entrance of her building. The claimant was diagnosed with a lumbar sprain/strain, cervical sprain/strain and bilateral knees sprain/strain with tenosynovitis. The claimant reported on 8/13/03 to Bryan Weddle, D.C. for evaluation and treatment. Passive and active modalities were begun. A left knee MRI was performed on 8/27/03 that revealed a bone bruise involving the medial femoral condyle, chondromalacia patella, moderate to large joint effusion, degenerative changes, small Baker's cyst, and fluid noted in the popliteus muscle tendon sheath. A right knee MRI was performed on 8/27/03 that revealed chondromalacia patella, degenerative changes, fluid in the popliteus muscle tendon sheath and small to moderate joint effusion. On 10/27/03 an MRI of the lumbar spine was performed that revealed minor facet arthropathy noted at L4/5 and L5/S1, and otherwise unremarkable MRI of the lumbar spine. No disc bulge or protrusion was found at any level. On 10/3/03 the claimant underwent a physical performance evaluation that revealed the claimant was at a sedentary level, which was underneath her medium physical demand level job duty. Daily handwritten notes were submitted for review. The treating doctor reported that an impairment evaluation was performed on 12/12/03 and the claimant was released from care.

Requested Service(s)

The medical necessity of the outpatient services including chiropractic manipulations, office visits, consultations, mechanical traction, therapeutic exercises, supplies, NCV motor nerves with and without F-wave, NCV sensory, H-reflex, manual therapies and needle EMGs dated from 11/3/03 through 12/12/03.

Decision

I disagree with the carrier and find that the therapeutic exercises (97110) dated 11/3/03, 11/5/03, 11/7/03, 11/10/03, 11/12/03, 11/14/03, and 11/17/03 were medically necessary. I also disagree with the carrier and find that office visit (99212) dated 11/26/03 was medically necessary.

I agree with the carrier that the remainder of the services in dispute were not medically necessary.

Rationale/Basis for Decision

According to the letter of medical necessity, the claimant was injured on ___ when she slipped and fell while entering a building. The claimant was diagnosed with a lumbar sprain/strain, cervical sprain/strain, bilateral knees sprain/strain and right elbow sprain/strain. It appears the claimant underwent passive therapies with a transition to active therapies, which appeared to be

reasonable and medically necessary to treat the compensable injury. On the dates of service in question beginning on 11/3/03, the claimant was still being treated with passive modalities that are not seen as medically necessary approximately 10 weeks post injury. Therapeutic exercises would help to provide increased range of motion and return to pre-injury status and would be seen as medically necessary. After approximately 12 weeks of therapy, a transition to a home based exercise program would be medically necessary, therefore, all passive and active modalities rendered on 11/19/03 and beyond are not seen as reasonable or medically necessary. The claimant underwent multiple MRIs that only revealed pre-existing conditions. The MRI of the lumbar spine was unremarkable and revealed no disc bulges or protrusions. The documentation supplied did not reveal any radiculopathies, therefore, the NCV and EMG testing performed on 11/11/03 and 11/20/03 are not seen as reasonable or medically necessary to treat the compensable injury. In order to assess continued progress in the claimant's case, the office visit dated 8/26/03 is seen as reasonable. Under workers' compensation guidelines, an impairment rating is also necessary in the treatment and evaluation of the claimant.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this __18th_____ day of __October_____ 2004.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder